

MEMORANDUM

To: Division of Medical Assistance
Claims Analysis Unit

From: _____
_____ County Department of Social Services

Telephone Number: _____

Date: _____
Re: Request for Claims Override

COMPLETE ALL PERTINENT SECTIONS

Recipient: _____ MID: _____
Date of Application: _____ Date of Disposition: _____

Reason for override request: **(There are NO other acceptable reasons.)**

- ☐ Social Security/SSI disability approval after a Medicaid disability denial:
- ☐ SSA/SSI disability denial (adopted by Medicaid) subsequently reversed by
SSA. Onset of disability: _____
- Date notice of approval received by dss: _____

**Authorization limited to the later of the date of application or onset of
Disability.**

- ☐ Medicaid disability denial (not adopted SSA/SSI decision) subsequently
approved by SSA. Onset of disability: _____
- Date county dss learned of SSA/SSI approval: _____

**Authorization limited to 12 months prior to the county's learning of
SSA/SSI approval.**

- ☐ County/State hearing decision in favor of the a/r.
Date DSS-1894 "Notice of Decision" received by dss: _____
- ☐ Court order in favor of the a/r.
- ☐ County administrative error. Date error discovered by dss: _____
Cause of error: _____

Authorization limited to 12 months prior to discovery of error.

- ☐ Application opened/reopened when the applicant was discouraged from applying,
encouraged to withdraw an application, or the application was improperly denied.
- ☐ County dss learned of approval of an SSI/SDX application.

Eligible dates in EIS for which override is needed:

Send notice of override approval to ☐ Recipient ☐ Responsible person

Responsible person: Name _____
Address _____

To: _____ Department of Social Services

From: Claims Analysis Unit
Division of Medical Assistance

Recipient: _____ MID: _____

OVERRIDE APPROVAL

Override authorization is **approved** for this recipient for the following date(s):

Advise the recipient to inform all medical providers to file outstanding claims directly with EDS, the Medicaid contractor, no later than _____

If the recipient is deceased or otherwise unable to notify providers, the IMC must follow Procedures in MA-2395/MA-3395, VI.D.7.b.

OVERRIDE DENIAL

The override request is denied for all or part of the date(s) because:

- ☐ Failure of the provider to file timely is not a basis for override.
- ☐ The claims filing time limit has not expired. No override is needed.
- ☐ The request does not meet policy guidelines. See M-AABD, MA-2395 or FC, MA-3395. Advise providers to submit claims to DMA, Claims Analysis Unit, for special handling Within 45 days of date of decision indicated below.

☐ Other: _____

Date

Claims Analyst, DMA